DEPARTMENT OF INSURANCE
STATE OF ARIZONA
Financial Affairs Division - Compliance Section
2910 North 44th Street, Suite 210
Phoenix, Arizona 85018-7269
Phone: (602) 364-3998
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ANNUAL STATEMENT WORKSHEET FOR ALL COMPANIES FILING A HEALTH ANNUAL STATEMENT

ENTER THE CALENDAR YEAR FOR THIS ANNUAL STATEMENT WORKSHEET:_____

NAIC#_____ COMPANY:_____ DOMICILE:_____

CHECK ONE TYPE:		COMPANY TYPE	DUE DATE
DOMESTIC		DISABILITY (ONLY) INSURER	MARCH 31
		LIFE/DISABILITY INSURER	
		PROPERTY/CASUALTY INSURER	
FOREIGN		DISABILITY (ONLY) INSURER	MARCH 01
		LIFE/DISABILITY INSURER	
		PROPERTY/CASUALTY	
ALL		HEALTH CARE SERVICES ORGANIZATION	MARCH 31
DOMESTIC		HOSPITAL, MEDICAL, DENTAL, OPTOMETRIC SERVICE CORPORATION	MARCH 31
ALL		PREPAID DENTAL PLAN ORGANIZATION	MARCH 01

SECTION I: REQUIREMENTS APPLICABLE TO ALL COMPANY TYPES LISTED ABOVE UNLESS NOTED OTHERWISE. *INITIAL AT LEFT OF EACH ITEM COMPLETED AND ENCLOSED*

Initial if Enclosed ↓ ↓ ↓		Initial at Left if Items are enclosed with Annual Statement	Agency Use Only ↓ ↓ ↓
_____	**A.**	Annual Statement – 8-1/2" X 14" Orange Jacket, (Securely Bound in two-sided book)	_____
		MUST INCLUDE THE FOLLOWING TO BE COMPLETE:	
		1. Jurat Page	_____
_____		a. Two Authorized Signatures (Signers MUST be Principal Officers Listed On the Jurat Page)	
_____		b. **DOMESTIC COMPANY ONLY** must have **ORIGINAL signatures**	
_____		c. Notarized Signatures	
_____		2. Actuarial Opinion NOTE: If Reserves = ZERO MUST ENTER N/A in box →	_____
		See Section II instructions if an exemption has been granted.	
_____		3. Arizona State Pages 30 **and** Supplement 23 or 59, as applicable	_____
_____	**B.**	Management Discussion & Analysis Report with Transmittal Form E-MDA (due April 1).....	_____
_____	**C.**	**DOMESTIC COMPANY ONLY:** State Pages 30 **and** Supplement 23 or 59, as applicable for each jurisdiction where Insurer transacted business	
_____	**D.**	**DOMESTIC COMPANY ONLY: DUPLICATE FILINGS** exact copy of each original document listed below:	
_____		1. Annual Statement, stamped "COPY" on the front cover, with	_____
_____		a. Actuarial Opinion, stamped "copy"	
_____		b. State Page for each jurisdiction where Insurer transacted business.....	
_____		2. IF APPLICABLE: "Arizona Business Only Pages" (see Section II for HCSO's), stamped "copy"	
_____		3. Management Discussion and Analysis Report with Transmittal Form E-MDA, stamped "copy".....	
_____		4. Form E-WORKSHEET.HEALTH, stamped "copy"	

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ARIZONA DEPARTMENT OF INSURANCE
ANNUAL STATEMENT WORKSHEET FOR ALL COMPANIES FILING A HEALTH ANNUAL STATEMENT

NAIC #_____ COMPANY:_____ DOMICILE:_____

(SECTION I continued)

_____ **E.** **LIFE/DISABILITY INSURER ONLY:** Certificate of Valuation ..... ☐

_____ **F.** **FOREIGN COMPANY ONLY:** Certificate of Compliance ..... ☐

_____ **G.** IF AVAILABLE, Audited Financial Report with completed Transmittal Form E-AFR (due June 1) ..... ☐

SECTION II: *ADDITIONAL* REQUIREMENTS APPLICABLE TO SPECIFIED COMPANY TYPE. *INITIAL AT LEFT OF EACH ITEM COMPLETED AND ENCLOSED*

Initial if Enclosed Only ↓ ↓ ↓	Initial at Left if Items are enclosed with Annual Statement	Agency Use Only ↓ ↓ ↓
	HEALTH CARE SERVICES ORGANIZATION	
_____	**H.** **ONLY if doing business in other states:** "Arizona Business Only" Pages 4, 7, and 14 Part 3, 17, 23, and 30 *See Form E-INSTRUCTION.HEALTH Section II for HCSO's only* IF NOT DOING BUSINESS IN OTHER STATES, ENTER N/A IN BOX → ☐	_____
_____	**I.** Form E-178 Certificate of Disclosure MUST INCLUDE TO BE COMPLETE:	_____
_____	1. E-178, Part A must be answered yes or no (If yes, must have attachment)	☐
_____	2. E-178, Part B must be answered yes or no (If yes, must have attachment)	☐
_____	3. a. Two Executive Office Original Signatures ..... (Signers Names MUST be Listed on the Jurat Page)	☐
_____	b. Notary signature and stamp or seal	☐
_____	**J.** Form E-HCSO-13 Certificate of Advertising Compliance	_____
_____	**K.** Updated Plan for Risk of Insolvency	_____
	HOSPITAL, MEDICAL, DENTAL, OPTOMETRIC SERVICE CORPORATION	
_____	**H.** Form E-HMDO-178 Certificate of Disclosure MUST INCLUDE TO BE COMPLETE:	_____
_____	1. E-178, Part A must be answered yes or no (If yes, must have attachment)	☐
_____	2. E-178, Part B must be answered yes or no (If yes, must have attachment)	☐
_____	3. a. Two Executive Office Original Signatures ..... (Signers Names Must be Listed on the Jurat Page)	☐
_____	b. Notary signature and stamp or seal	☐
_____	**I.** **ONLY if the HMDO has an HCSO operation:**	
_____	1. Form E-HCSO-13 Certificate of Advertising Compliance	_____
_____	2. Updated Plan for Risk of Insolvency	_____
	PREPAID DENTAL PLAN ORGANIZATION and DOMESTIC: DISABILITY INSURER, LIFE/DISABILITY INSURER OR PROPERTY/CASUALTY INSURER	
	MAIL UNDER SEPARATE COVER TO ATTENTION: COMPLIANCE SECTION:	
_____	**I.** Annual Insurance Holding Company System Registration Statement Forms B and C (due March 31)...	☐
	ALL DISABILITY INSURERS, LIFE/DISABILITY INSURERS, PROPERTY/CASUALTY INSURERS	
_____	**I.** Form E-178 Certificate of Disclosure MUST INCLUDE TO BE COMPLETE:	_____
_____	1. E-178, Part A must be answered yes or no (If yes, must have attachment)	☐
_____	2. E-178, Part B must be answered yes or no (If yes, must have attachment)	☐
_____	3. a. Two Executive Office Original Signatures ..... (Signers Names Must be Listed on the Jurat Page)	☐
_____	b. Notary signature and stamp or seal	☐

PREPARED BY: *(must complete PRINT OR TYPE CLEARLY)*

NAME & TITLE	COLLECT/TOLL FREE PHONE NUMBER	E-MAIL ADDRESS